No. 2
—5-42
—17-39
X32

FILED NOV 9 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Byrne — 34160 State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1166

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 913 Ridenbaugh 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 15 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Wyandotte 991
(c) City or town Kansas City Kansas 14
(If outside city or town limits, write "RURAL") 0
(d) Street No. 715 Greenlee Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country. 2

3. (a) PRINT FULL NAME Mrs. Ella Grindrod
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or race / White
6. (a) Single, widowed, married, divorced 2 Widowed
6. (b) Name of husband or wife Kay Grindrod
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased February 1st. 1863 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
80	10	27	hr. min.

9. Birthplace Dont Know (City, town, or county) 4 (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER 12. Name Samuel S. Kinner
13. Birthplace England (City, town, or county) 4 (State or foreign country)
MOTHER 14. Maiden name Elizabeth D'Wyer
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)
16. (a) Informant Miss. Ella M. Dolan
(b) Address 913 Ridenbaugh. St Joseph Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/28/43 (Month) (Day) (Year)
(c) Place: burial or cremation Lawrence Kans.
18. (a) Signature of funeral director Herman Wm Sidenfaden
(b) Address 1802 Union St. St Joseph. Mo.
19. (a) 10-28-43 (Date received local registrar) (b) Rose Herzig (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28 year 1943 hour 6:55 minute A. M.
21. I hereby certify that I attended the deceased from Oct 1-43, 19 to Oct. 28th. 1943 that I last saw her alive on Oct 28 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Aortic insufficiency / unknown — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Wm I Byrne (M. D. or other)
Address St Joseph Mo Date signed 10-28-43

1233 (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... Leon E. Hodge

Licensed Embalmer No. 2729

P. O. Address St Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

...o. 2B
—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 10

State File No.

Registration District No. 42 | Primary Registration District No. 1003 | Registrar's No. 1166

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ella Grindrod

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Feb. 1 (Month) (Day) 1863 (Year)

8. AGE: Years 80 | Months 10 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8
year 1943 hour 6 minute M.

21. I hereby certify that I attended the deceased from , 19 , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis (Duration)

Due to Cause unknown

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 130

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature John L Allen (M. D. or other)
Address Date signed

SUPPLEMENTARY
O.K

34160